REPRODUCE LOCALLY. *Include form number and date on all reproductions.*

FFAS-1046
(10-15-01)

FFAS LEAVE BANK PROGRAM - RECIPIENT APPLICATION

FOR PERSONNEL USE ONLY:

INSTRUCTIONS: Use this form to apply as a recipient in the leave bank program under 5 CFR Part 630, Section 630.1001. Attach to this form the appropriate medical documentation describing your medical emergency. The medical documentation shall include diagnosis or prognosis and anticipated duration of the condition. After completing this form, have your supervisor sign concurrence and FAX your application to the Leave Bank Coordinators in HRD-PMBAB. You will be notified of approval or disapproval.

Part A - Completed by Recipient *(This application may be completed by someone acting on behalf of the recipient)*

1. NAME OF APPLICANT *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NUMBER

3. POSITION TITLE	4. SERIES, GRADE, PAY LEVEL	5. ORGANIZATIONAL TITLE *(Agency, Division, Branch, Section)*

6. OFFICE LOCATION AND STOP CODE	7. OFFICE TELEPHONE NUMBER	8. APPLICANT HOME TELEPHONE NUMBER

9. NAME OF TIMEKEEPER	10. TIMEKEEPER TELEPHONE NUMBER	11. TIMEKEEPER FAX NUMBER

12. ANTICIPATED OR ACTUAL DURATION OF MEDICAL EMERGENCY *(if known)*		13. APPROXIMATE NUMBER OF LEAVE HOURS NEEDED FOR THIS EMERGENCY
Beginning Date	Ending Date	

14. TYPE OF MEDICAL EMERGENCY

☐ PERSONAL MEDICAL ☐ FAMILY MEDICAL *(See NOTE below)*

NOTE: When applying to be a recipient due to the medical emergency of a family member, all entitlements to Sick Leave for Family Care (SLFC) must be exhausted. Sick Leave for Family Care ***(SLFC)*** information can be found in 17-PM, Part 10, Section 3, Page 10-115.

Part B - Recipient or Designee and Supervisor Certification

I certify that (1) I have been affected by the medical emergency described in the attachment since the date indicated above, (2) expect to be absent from duty without paid leave for at least a 24 hours due to medical a emergency. I further certify that I am not receiving unemployment benefits or workers' compensation benefits in connection with this medical emergency which I am requesting leave donations for.

15. SIGNATURE OF APPLICANT OR DESIGNEE	16. DATE

17. SIGNATURE OF SUPERVISOR	18. DATE	19. CONCURRENCE	20. SUPERVISOR'S TELEPHONE NUMBER
		☐ YES ☐ NO	

Part C - Agency Review and Board Approval

21. APPLICANT'S CURRENT ANNUAL LEAVE BALANCE	22. APPLICANT'S CURRENT SICK LEAVE BALANCE	23. APPLICATION STATUS
		☐ APPROVED ☐ DISAPPROVED

24. REASON FOR DISAPPROVAL

25. SIGNATURE OF LEAVE BANK BOARD OFFICIAL	26. DATE	27. NUMBER OF LEAVE BANK HOURS PROVIDED TO RECIPIENT

28. LEAVE CATEGORY TO APPLY DONATED LEAVE

☐ CURRENT USE ☐ ADVANCED SICK LEAVE ☐ ADVANCED ANNUAL LEAVE ☐ LWOP

Part D- Application Submission *(After submitting please call Leave Bank Coordinator to verify application was received)*

29. FAX NUMBER (202) 418-9129
Attn: Leave Bank Coordinator
FFAS HRD PMBAB

PRIVACY ACT STATEMENT

U.S.C 6311 authorizes collection of this information. Your social security number is requested solely for the purposes of positively identifying leave donors so that donated leave can be deducted from the proper account. Although the disclosure of this information is voluntary, failure to furnish this information may result in disapproval of this application.